Recommendations for Improving Relationships Between Consumers and Faith-Based and Community Organizations

Drawing on the factors identified, participants developed a set of recommendations for improving relationships between consumers and faith-based and community organizations. These recommendations reflect the combined thinking of the participants, but not a consensus. The group's recommendations are presented below, organized by broad target audience and then by major theme. The primary audiences for these recommendations are SAMHSA and other HHS agencies, faith-based organizations, consumers and consumer advocates, and other interested individuals and organizations. Some recommendations appear in more than one category.

Recommendations to SAMHSA/CMHS

1. Provide education to faith-based and community organizations.
    a. Develop educational curricula and programs to assist faith-based and community organizations in learning about mental illnesses and co-occurring disorders. Suggested topics include
        i. What are mental illnesses and psychiatric disabilities?
        ii. Reducing or eliminating discrimination and stigma
        iii. Recovery
        iv. Importance of faith and spirituality in mental health recovery; need for a "healing place"
        v. Creating a supportive, welcoming environment
        vi. Techniques for outreach (including assessment)
        vii. Possibility of relapse and its implications for long-term relationships between consumers and the faith community
        viii. Cultural competence
        ix. Grant-writing skills

x. Federal, State, and local mental health agencies and programs

xi. How to help consumers navigate the mental health system; how and when to make referrals to appropriate supports

b. Facilitate ways for faith-based organizations to consider their responsibility to assist people with mental health issues in meeting their basic needs, such as housing, social service and vocational supports, and other resources. Encourage clergy and lay leaders of faith-based organizations, as part of their mission, to address the needs of mental health consumers. Address the needs of clergy with mental illnesses facing discrimination and stigma.

2. Enhance education for health care and social service providers.

   a. Develop an educational program to assist health care, mental health care, and social services providers in understanding the importance of faith and spirituality in recovery. Include explicit guidelines and training on spirituality in recovery.

   b. Include information for and about faith-based organizations in all SAMHSA materials (for example, add a fact sheet to the CMHS Anti-Stigma Kit).

   c. Work with schools of medicine, psychology, nursing, and social work to add to their curricula a focus on a holistic approach to wellness that integrates physical and mental health and the role of spirituality.

   d. Sponsor development of (1) instruments that can assess a person's spiritual history, interests, and mental health needs; (2) techniques to integrate that information into treatment planning; and (3) competencies for mental health providers to address their clients' spiritual needs.

3. Create ongoing dialogue and foster partnerships between mental health agencies and faith-based communities.

   a. Initiate communication among SAMHSA and faith-based organizations, including clergy and lay representatives of faith-based organizations serving on national advisory councils and consumer subcommittees.

   b. Encourage collaboration and interaction among the faith community, consumers, family members, advocates, providers, community organizations, and government agencies. Provide incentives to bring communities together to implement recommendations.

c. Sponsor regional dialogues among health and mental health professionals, clergy and lay faith community leaders, and consumers. Develop, publish, and disseminate guidance for State and local entities to host similar dialogues.

d. Develop a video on how to forge partnerships between consumers and faith-based and community organizations.

e. Encourage the development of links between public health agencies and faith-based organizations. For example, some public health care agencies turn to local congregations to contribute funds to pay for medications for people who cannot afford them.

4. Encourage consumer involvement.

   a. Encourage consumer participation at all levels of planning, research, education, program development, and policy.

   b. Assist consumer groups in compiling reference manuals for the benefit of clergy, schools, and other groups regarding mental health and social support resources in their communities.

5. Promote best-practices models.

   a. Publish success stories of persons with mental illnesses engaged in the life of faith communities.

   b. Compile a list of best-practices models and resources and develop strategies to share lessons learned.

   c. Create a Web site and listserv to exchange information on successful faith-based and consumer initiatives.

6. Provide Federal assistance, monitoring, evaluation, and feedback.

   a. Recommend that the U.S. Department of Health and Human Services establish a national advisory council to enable faith-based and community organizations to inform policy development.

   b. Outline a strategy to determine incremental, achievable, and measurable goals that can be implemented for system change related to the inclusion of faith and spirituality in mental health service delivery.

   c. Monitor Federal funding of the faith-based and community initiative to ensure that organizations that provide mental health services have the opportunity to apply for funding.

   d. Monitor faith-based services to ensure that the quality of mental health services and professionals are maintained and promoted.

e. Establish dissemination and communication strategies and feedback mechanisms for activities related to the faith-based and community initiative.

7. Foster research.
   a. Conduct research on impediments to integration of persons with mental health issues into the faith community. Investigate factors that inhibit and promote interaction.
   b. Conduct research on the role of chaplains in the recovery process, perhaps in conjunction with the Department of Veterans Affairs.
   c. Develop criteria to evaluate the effectiveness of faith-based mental health programs.
   d. Include grants for faith-based organizations in small communities.

Recommendations to Faith-Based Organizations

1. Create a welcoming, supportive environment for mental health consumers.
   a. Learn how consumers can request help from congregations and establish openness to these contacts.
   b. Educate ushers, greeters, and other lay persons to welcome people with mental illnesses.
   c. Address the unique needs of individuals with mental illnesses.
   d. Take a strengths-based approach that includes the expectation for recovery.
2. Introduce instruction on mental health and mental illnesses as required topics in seminary education.
3. Use CMHS's "Participatory Dialogue" guide to organize dialogues in local communities.
4. Create partnerships between consumers and faith-based organizations for education.
   a. Enable faith communities to interact directly with consumers.
   b. Teach faith-based organizations to reach out to consumers with mental health issues, including determining who they are, how to contact them, and identifying their needs.
   c. Host forums on issues related to mental health and mental illness.
   d. Invite consumers to share their stories to bring a face to recovery, to explain the role that spirituality played to help

them recover, and to help clergy and chaplains understand how to support consumers who want to look at their experiences in a spiritual context, as well as, or instead of, an illness context.

e. Compile inspirational writings to stimulate communication about consumers' journeys.

5. Develop curricula to address and demythologize mental illness for adults and children suitable for use and adaptation by faith-based organizations.
6. Develop a fact sheet on faith and spirituality in mental health.
7. Increase awareness and skills related to cultural competence.
   a. Use nondiscriminatory, nonstigmatizing language regarding mental health issues.
   b. Accommodate the language and other needs of individuals from diverse cultures.
8. Address issues of discrimination and stigma.
   a. Avoid decision-making based on stereotypes, stigma, and imagined worst-case scenarios regarding persons with mental illnesses.
   b. Mitigate discrimination and stigma in the thinking of both members and clergy.
   c. Deal openly, positively, and compassionately with clergy who have their own mental health issues.
9. Educate mental health providers about the role of chaplains in psychiatric hospitals as part of the treatment team.
10. Provide support for the grieving process related to having a disability, which includes mental illnesses.
11. Consider the social ramifications of mental illnesses and work to improve conditions such as housing and employment.
12. Include consumers on committees and governing boards of faith-based organizations.
13. Provide transportation resources to enable consumers to participate in the activities of faith communities.

Recommendations to Consumers and Consumer Advocates

1. Develop a compendium of best practices and lessons learned about engaging faith communities to create supportive, welcoming environments for people with mental health issues.
2. Develop guidelines for faith-based organizations on factors involved in creating a supportive, welcoming environment.

3. Educate consumers and consumer groups on techniques to engage with faith-based organizations and to create change.
4. Contribute to the development of curricula about the needs of persons with mental health issues and faith-based programs.
5. Volunteer to share faith-based stories with congregations in order to put a face on recovery and the role that spirituality plays in recovery; establish local speakers bureaus of consumers willing to share their stories.
6. Present at consumer conferences on the role of spirituality in recovery and how to create positive change in faith-based organizations so that they welcome people with mental health issues.
7. Organize dialogues between faith-based organizations and mental health consumers.
8. Volunteer in community efforts (for example, in homeless shelters) to demonstrate the hope and reality of recovery—and to give back to the community.
9. Generate publicity for the positive role that faith communities play in the recovery of persons with mental illnesses.
10. Create and disseminate templates for consumer letter-writing campaigns to clergy and lay leaders of faith-based organizations.
11. Encourage consumer participation at all levels of planning, research, education, program development, and policy.
12. Mobilize consumer groups to prepare reference manuals on mental health and other social support resources in their communities for the benefit of clergy, schools, and other groups.
13. Promote consumer participation on governing boards and committees of faith communities.

These recommendations may serve as a menu for agencies, organizations, and individuals who wish to adapt the ideas for implementation in their own communities.